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CHALENG 2005 Survey: VA Outpatient Clinic (Toledo, OH), VA Ann Arbor HCS, MI - 506

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 200

2. Estimated Number of Veterans who are Chronically Homeless: 84

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 200 (estimated number of homeless veterans in service area) **x chronically homeless rate (42 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	686	180
Transitional Housing Beds	748	40
Permanent Housing Beds	146	800

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 12

3. CHALENG Point of Contact Action Plan for FY 2005

Child care	Not especially relevant to homeless veterans. Most homeless veterans are males and estranged from their children. However, the number of female veterans is increasing.
Legal Assistance	Will utilize Legal Aid, ARLE, and explore law school legal services for the indigent. Will also explore pro-bono work by local bar associations.
Long-term, permanent housing	Will continue to support and promote permanent housing projects with supportive services in our communities.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **44** **Non-VA staff Participants: 81.8%**
Homeless/Formerly Homeless: **11.4%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.95	.0%	3.47
Food	4.30	9.0%	3.80
Clothing	4.05	3.0%	3.61
Emergency (immediate) shelter	3.66	23.0%	3.33
Halfway house or transitional living facility	3.50	18.0%	3.07
Long-term, permanent housing	2.69	29.0%	2.49
Detoxification from substances	3.73	6.0%	3.41
Treatment for substance abuse	3.88	15.0%	3.55
Services for emotional or psychiatric problems	3.8	12.0%	3.46
Treatment for dual diagnosis	3.7	9.0%	3.30
Family counseling	3.23	9.0%	2.99
Medical services	4.05	12.0%	3.78
Women's health care	3.62	6.0%	3.23
Help with medication	3.78	.0%	3.46
Drop-in center or day program	3.33	.0%	2.98
AIDS/HIV testing/counseling	3.82	.0%	3.51
TB testing	4.18	.0%	3.71
TB treatment	4.03	.0%	3.57
Hepatitis C testing	4.11	.0%	3.63
Dental care	3.23	15.0%	2.59
Eye care	3.62	6.0%	2.88
Glasses	3.75	.0%	2.88
VA disability/pension	3.69	15.0%	3.40
Welfare payments	3.26	.0%	3.03
SSI/SSD process	3.30	6.0%	3.10
Guardianship (financial)	3.29	.0%	2.85
Help managing money	3.28	9.0%	2.87
Job training	3.30	12.0%	3.02
Help with finding a job or getting employment	3.17	26.0%	3.14
Help getting needed documents or identification	3.78	3.0%	3.28
Help with transportation	3.30	15.0%	3.02
Education	3.05	18.0%	3.00
Child care	2.47	6.0%	2.45
Legal assistance	2.72	9.0%	2.71
Discharge upgrade	3.64	.0%	3.00
Spiritual	3.54	6.0%	3.36
Re-entry services for incarcerated veterans	3.16	9.0%	2.72
Elder Healthcare	3.10	6.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.85
Co-location of Services - Services from the VA and your agency provided in one location.	2.03
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.67
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.50
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.91
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.72
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.09
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.69
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.22
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.90
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.74
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.97

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.94
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.00

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CHALENG 2005 Survey: VA Northern Indiana HCS (VAMC Fort Wayne - 610A4 and VAMC Marion - 610)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 300

2. Estimated Number of Veterans who are Chronically Homeless: 99

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 300 (estimated number of homeless veterans in service area) **x chronically homeless rate (33 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	220	75
Transitional Housing Beds	0	86
Permanent Housing Beds	0	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Continue to encourage community agencies to apply for VA Grant and Per Diem funds as they become available. Increase provision of information to local VA decision-makers regarding HUD Continuum of Care planning.
Long-term, permanent housing	Continue to discuss individual client situations with community agencies, using each situation as an opportunity to request that permanent housing be set aside for homeless veterans. Increase provision of information to local VA decision-makers regarding
Immediate shelter	There has been no new emergency beds added in the area in the past fiscal year. Continue to discuss needs with homeless task forces and as part of the HUD Continuum of Care planning process. Increase provision of information to local VA decision-makers

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **20** **Non-VA staff Participants: 68.4%**
Homeless/Formerly Homeless: **5.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.68	.0%	3.47
Food	3.95	12.0%	3.80
Clothing	4.05	6.0%	3.61
Emergency (immediate) shelter	3.16	22.0%	3.33
Halfway house or transitional living facility	2.75	35.0%	3.07
Long-term, permanent housing	2.15	41.0%	2.49
Detoxification from substances	3.10	6.0%	3.41
Treatment for substance abuse	3.25	12.0%	3.55
Services for emotional or psychiatric problems	3.6	18.0%	3.46
Treatment for dual diagnosis	3.1	12.0%	3.30
Family counseling	2.79	12.0%	2.99
Medical services	3.30	12.0%	3.78
Women's health care	3.10	.0%	3.23
Help with medication	3.30	6.0%	3.46
Drop-in center or day program	2.30	6.0%	2.98
AIDS/HIV testing/counseling	3.11	.0%	3.51
TB testing	3.42	.0%	3.71
TB treatment	3.25	.0%	3.57
Hepatitis C testing	3.35	.0%	3.63
Dental care	2.75	12.0%	2.59
Eye care	2.75	6.0%	2.88
Glasses	2.55	.0%	2.88
VA disability/pension	3.11	6.0%	3.40
Welfare payments	2.60	.0%	3.03
SSI/SSD process	3.05	6.0%	3.10
Guardianship (financial)	2.70	.0%	2.85
Help managing money	2.47	.0%	2.87
Job training	2.80	18.0%	3.02
Help with finding a job or getting employment	2.85	35.0%	3.14
Help getting needed documents or identification	2.85	.0%	3.28
Help with transportation	2.30	6.0%	3.02
Education	2.30	6.0%	3.00
Child care	1.90	6.0%	2.45
Legal assistance	2.20	6.0%	2.71
Discharge upgrade	2.79	.0%	3.00
Spiritual	3.15	.0%	3.36
Re-entry services for incarcerated veterans	2.35	.0%	2.72
Elder Healthcare	2.90	6.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.17
Co-location of Services - Services from the VA and your agency provided in one location.	1.33
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.50
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.33
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.50
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.50
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.67
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.42
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.42
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.33
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.58

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.38
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.08

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CHALENG 2005 Survey: VAMC Battle Creek, MI - 515

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 750

2. Estimated Number of Veterans who are Chronically Homeless: 173

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 750 (estimated number of homeless veterans in service area) **x chronically homeless rate (23 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	180
Transitional Housing Beds	90	100
Permanent Housing Beds	170	200

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 17

3. CHALENG Point of Contact Action Plan for FY 2005

Dental care	Continue to solicit dental services in the community for pro-bono or low-cost services. Cherry Street Dental in Grand Rapids will extract for free. Continue good relationship with Dental Services at Battle Creek VAMC.
Long-term, permanent housing	Battle Creek continues to have a permanent housing problem. Lansing and Grand Rapids have both received Section 8 vouchers.
Job training	Continue to refer to "Michigan Works," CWT and local employment groups to assist with jobs/job placement. Michigan has lost many factories/large employers in key cities of Battle Creek, Lansing, and Grand Rapids.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **81** **Non-VA staff Participants: 86.3%**
Homeless/Formerly Homeless: **50.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.81	.0%	3.47
Food	3.73	9.0%	3.80
Clothing	3.46	14.0%	3.61
Emergency (immediate) shelter	3.58	16.0%	3.33
Halfway house or transitional living facility	3.13	21.0%	3.07
Long-term, permanent housing	2.57	32.0%	2.49
Detoxification from substances	3.39	14.0%	3.41
Treatment for substance abuse	3.53	9.0%	3.55
Services for emotional or psychiatric problems	3.2	7.0%	3.46
Treatment for dual diagnosis	3.2	5.0%	3.30
Family counseling	2.85	2.0%	2.99
Medical services	3.26	11.0%	3.78
Women's health care	3.18	5.0%	3.23
Help with medication	3.20	5.0%	3.46
Drop-in center or day program	3.20	4.0%	2.98
AIDS/HIV testing/counseling	3.52	2.0%	3.51
TB testing	3.55	2.0%	3.71
TB treatment	3.38	.0%	3.57
Hepatitis C testing	3.36	.0%	3.63
Dental care	2.40	29.0%	2.59
Eye care	2.69	16.0%	2.88
Glasses	2.74	4.0%	2.88
VA disability/pension	2.91	11.0%	3.40
Welfare payments	2.84	2.0%	3.03
SSI/SSD process	3.12	16.0%	3.10
Guardianship (financial)	2.86	4.0%	2.85
Help managing money	2.75	2.0%	2.87
Job training	2.76	13.0%	3.02
Help with finding a job or getting employment	2.76	12.0%	3.14
Help getting needed documents or identification	3.27	2.0%	3.28
Help with transportation	2.90	16.0%	3.02
Education	3.02	7.0%	3.00
Child care	2.83	4.0%	2.45
Legal assistance	2.81	4.0%	2.71
Discharge upgrade	2.86	2.0%	3.00
Spiritual	3.67	4.0%	3.36
Re-entry services for incarcerated veterans	2.60	7.0%	2.72
Elder Healthcare	3.05	2.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.57
Co-location of Services - Services from the VA and your agency provided in one location.	2.29
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.14
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.20
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.14
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.98
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.12
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.27
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.18
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.02
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.96
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.16

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.55
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.50

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CHALENG 2005 Survey: VAMC Danville, IL - 550

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 900

2. Estimated Number of Veterans who are Chronically Homeless: 396

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 900 (estimated number of homeless veterans in service area) **x chronically homeless rate (44 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	0
Transitional Housing Beds	60	90
Permanent Housing Beds	70	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Treatment for substance abuse	Access to substance abuse treatment increasing through new FTE at VA Medical Center and Community Based Outpatient Clinics.
Services for emotional or psychiatric problems	Access to substance abuse treatment increasing through new FTE at VA Medical Center and Community Based Outpatient Clinics.
Help finding a job or getting employment	Access to vocational assistance for severely mentally ill increasing through implementation of Supported Employment/Compensated Work Therapy Program. Will refer eligible veterans to this program.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **8** **Non-VA staff Participants: 50.0%**
Homeless/Formerly Homeless: **12.5%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.38	13.0%	3.47
Food	3.86	.0%	3.80
Clothing	4.00	.0%	3.61
Emergency (immediate) shelter	3.71	.0%	3.33
Halfway house or transitional living facility	4.00	.0%	3.07
Long-term, permanent housing	3.14	25.0%	2.49
Detoxification from substances	3.75	13.0%	3.41
Treatment for substance abuse	3.86	38.0%	3.55
Services for emotional or psychiatric problems	3.9	25.0%	3.46
Treatment for dual diagnosis	4.0	13.0%	3.30
Family counseling	3.63	13.0%	2.99
Medical services	3.88	25.0%	3.78
Women's health care	3.43	13.0%	3.23
Help with medication	3.57	13.0%	3.46
Drop-in center or day program	2.71	.0%	2.98
AIDS/HIV testing/counseling	3.71	.0%	3.51
TB testing	3.71	.0%	3.71
TB treatment	3.71	.0%	3.57
Hepatitis C testing	4.00	13.0%	3.63
Dental care	2.13	13.0%	2.59
Eye care	2.63	13.0%	2.88
Glasses	2.63	13.0%	2.88
VA disability/pension	3.75	.0%	3.40
Welfare payments	3.29	.0%	3.03
SSI/SSD process	3.00	13.0%	3.10
Guardianship (financial)	3.14	.0%	2.85
Help managing money	2.57	.0%	2.87
Job training	3.57	.0%	3.02
Help with finding a job or getting employment	3.57	38.0%	3.14
Help getting needed documents or identification	3.43	.0%	3.28
Help with transportation	3.50	13.0%	3.02
Education	3.50	.0%	3.00
Child care	2.57	.0%	2.45
Legal assistance	2.50	.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	4.57	.0%	3.36
Re-entry services for incarcerated veterans	2.71	.0%	2.72
Elder Healthcare	3.14	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.00
Co-location of Services - Services from the VA and your agency provided in one location.	1.33
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.67
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.67
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.33
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.33
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.33
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.33
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.33
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.33

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Detroit, MI - 553

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 2150

2. Estimated Number of Veterans who are Chronically Homeless: 215

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 2150 (estimated number of homeless veterans in service area) **x chronically homeless rate (10 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	550	0
Transitional Housing Beds	260	50
Permanent Housing Beds	50	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Help finding a job or getting employment	The DVC is now a GPD provider and also a recipient of a good-sized HVRP grant through DOL. We have also recently hired a social worker to work exclusively with GPD programs. We anticipate a much closer and more productive relationship with DVC staff.
Long-term, permanent housing	We anticipate our actions in FY 2006 to be much the same as last year. However, with our new relationship with DVC we expect to have more access to Section 8 vouchers.
Transitional living facility or halfway house	Although we now have 104 transitional housing beds at the DVC we will continue to work with other agencies in the area to support and/or develop additional transitional housing opportunities.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **27** **Non-VA staff Participants: 77.8%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.15	.0%	3.47
Food	3.50	12.0%	3.80
Clothing	3.38	12.0%	3.61
Emergency (immediate) shelter	3.11	16.0%	3.33
Halfway house or transitional living facility	2.81	24.0%	3.07
Long-term, permanent housing	2.30	40.0%	2.49
Detoxification from substances	3.48	8.0%	3.41
Treatment for substance abuse	3.48	8.0%	3.55
Services for emotional or psychiatric problems	3.1	16.0%	3.46
Treatment for dual diagnosis	2.9	8.0%	3.30
Family counseling	2.78	.0%	2.99
Medical services	3.63	8.0%	3.78
Women's health care	3.30	4.0%	3.23
Help with medication	3.56	.0%	3.46
Drop-in center or day program	3.30	4.0%	2.98
AIDS/HIV testing/counseling	3.78	4.0%	3.51
TB testing	3.89	4.0%	3.71
TB treatment	3.85	.0%	3.57
Hepatitis C testing	3.85	.0%	3.63
Dental care	2.59	8.0%	2.59
Eye care	3.00	.0%	2.88
Glasses	3.07	4.0%	2.88
VA disability/pension	3.44	20.0%	3.40
Welfare payments	2.80	.0%	3.03
SSI/SSD process	3.08	.0%	3.10
Guardianship (financial)	2.88	.0%	2.85
Help managing money	2.54	8.0%	2.87
Job training	2.88	12.0%	3.02
Help with finding a job or getting employment	2.78	44.0%	3.14
Help getting needed documents or identification	3.20	12.0%	3.28
Help with transportation	2.52	16.0%	3.02
Education	2.89	.0%	3.00
Child care	2.77	.0%	2.45
Legal assistance	2.88	.0%	2.71
Discharge upgrade	3.04	.0%	3.00
Spiritual	3.32	8.0%	3.36
Re-entry services for incarcerated veterans	2.46	8.0%	2.72
Elder Healthcare	3.15	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.35
Co-location of Services - Services from the VA and your agency provided in one location.	1.95
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.65
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.40
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.35
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.35
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.80
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.40
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.25
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.45
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.50

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.67
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.45

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Indianapolis - 583

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1000

2. Estimated Number of Veterans who are Chronically Homeless: 280

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1000 (estimated number of homeless veterans in service area) **x chronically homeless rate (28 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	740	484
Transitional Housing Beds	1180	135
Permanent Housing Beds	1223	977

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Treatment for substance abuse	City is planning an Engagement Center "Sober Up Station" to prevent at risk homeless going to jail by being triaged to detox and treatment services.
Transitional living facility or halfway house	Plan to increase collaboration with non-profit providers and apply to future RFP's for Grant and Per Diem.
Transportation	Continue to provide bus fair, encourage veterans to obtain half-price disabled passes when appropriate, help facilitate service center transportation (HVAF) and Horizon House) and obtain more vans when possible.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **37** **Non-VA staff Participants: 72.2%**
Homeless/Formerly Homeless: **10.8%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.16	.0%	3.47
Food	3.21	21.0%	3.80
Clothing	3.48	7.0%	3.61
Emergency (immediate) shelter	3.13	26.0%	3.33
Halfway house or transitional living facility	3.36	15.0%	3.07
Long-term, permanent housing	3.13	22.0%	2.49
Detoxification from substances	2.73	15.0%	3.41
Treatment for substance abuse	3.30	19.0%	3.55
Services for emotional or psychiatric problems	3.3	14.0%	3.46
Treatment for dual diagnosis	3.1	4.0%	3.30
Family counseling	2.72	4.0%	2.99
Medical services	3.67	4.0%	3.78
Women's health care	3.07	7.0%	3.23
Help with medication	3.27	11.0%	3.46
Drop-in center or day program	3.20	.0%	2.98
AIDS/HIV testing/counseling	3.15	4.0%	3.51
TB testing	3.27	.0%	3.71
TB treatment	3.33	.0%	3.57
Hepatitis C testing	3.19	.0%	3.63
Dental care	2.87	19.0%	2.59
Eye care	3.03	.0%	2.88
Glasses	3.07	7.0%	2.88
VA disability/pension	3.55	21.0%	3.40
Welfare payments	3.14	.0%	3.03
SSI/SSD process	3.17	11.0%	3.10
Guardianship (financial)	2.88	.0%	2.85
Help managing money	2.73	7.0%	2.87
Job training	3.29	11.0%	3.02
Help with finding a job or getting employment	3.63	11.0%	3.14
Help getting needed documents or identification	3.32	.0%	3.28
Help with transportation	3.20	22.0%	3.02
Education	3.03	7.0%	3.00
Child care	2.48	4.0%	2.45
Legal assistance	2.71	.0%	2.71
Discharge upgrade	3.07	4.0%	3.00
Spiritual	3.19	.0%	3.36
Re-entry services for incarcerated veterans	2.89	4.0%	2.72
Elder Healthcare	2.83	7.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.00
Co-location of Services - Services from the VA and your agency provided in one location.	2.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.92
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.68
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.96
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.86
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.39
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.17
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.78
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.87
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.04

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.00
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.00

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Saginaw, MI - 655

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 7

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 7 (estimated number of homeless veterans in service area) **x chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	75	0
Transitional Housing Beds	78	0
Permanent Housing Beds	50	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Elder Healthcare	Begin planning for needs for this aging nucleus of homeless in the local area.
Long-term, permanent housing	We continue to see a need for singles with cooking facilities. Older buildings are deteriorating. The group has been tasked to reorganize and work on the task and report back to the committee.
Services for emotional or psychiatric problems	Community mental health need for additional services in the local area.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **15 Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **13.3%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.00	.0%	3.47
Food	3.36	.0%	3.80
Clothing	3.43	.0%	3.61
Emergency (immediate) shelter	3.13	14.0%	3.33
Halfway house or transitional living facility	2.71	21.0%	3.07
Long-term, permanent housing	2.27	43.0%	2.49
Detoxification from substances	3.00	7.0%	3.41
Treatment for substance abuse	3.07	14.0%	3.55
Services for emotional or psychiatric problems	2.6	29.0%	3.46
Treatment for dual diagnosis	2.7	21.0%	3.30
Family counseling	2.71	7.0%	2.99
Medical services	3.20	7.0%	3.78
Women's health care	2.85	.0%	3.23
Help with medication	3.15	7.0%	3.46
Drop-in center or day program	2.43	.0%	2.98
AIDS/HIV testing/counseling	3.14	.0%	3.51
TB testing	3.29	.0%	3.71
TB treatment	3.29	.0%	3.57
Hepatitis C testing	3.21	.0%	3.63
Dental care	2.50	7.0%	2.59
Eye care	2.79	.0%	2.88
Glasses	2.64	.0%	2.88
VA disability/pension	3.36	.0%	3.40
Welfare payments	3.07	.0%	3.03
SSI/SSD process	2.80	14.0%	3.10
Guardianship (financial)	2.93	.0%	2.85
Help managing money	2.64	14.0%	2.87
Job training	2.50	14.0%	3.02
Help with finding a job or getting employment	2.50	14.0%	3.14
Help getting needed documents or identification	2.93	.0%	3.28
Help with transportation	2.67	.0%	3.02
Education	2.79	7.0%	3.00
Child care	2.93	.0%	2.45
Legal assistance	3.00	7.0%	2.71
Discharge upgrade	2.86	.0%	3.00
Spiritual	3.14	7.0%	3.36
Re-entry services for incarcerated veterans	2.13	43.0%	2.72
Elder Healthcare	2.64	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.00
Co-location of Services - Services from the VA and your agency provided in one location.	1.40
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.47
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.71
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.27
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.13
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.27
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.47
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.53
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.20
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.40
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.60

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.07
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.14